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ABSTRACT

Self-help approaches to the treatment of problem drinking were investigated in five studies, including methods oriented toward controlled drinking as well as those designed to produce abstinence. Study 1 explored the utility of a self-help manual as an agent in improving maintenance following treatment by a paraprofessional. Clients who read this manual showed significantly better maintenance than did those not using the manual. Study 2 compared the effectiveness of the manual alone with that of a paraprofessional-administered program. Both groups showed substantial improvement, with no significant difference between groups; however, differences that did occur favored the bibliotherapy group. Study 3 was a demonstration of the feasibility of a group educational format in controlled drinking therapy. Study 4 compared bibliotherapy with one group and two individual treatment approaches. All groups showed significant improvement, again without between-group differences. Bibliotherapy clients in this study, however, showed the least favorable outcomes. Study 5 compared an expanded form of bibliotherapy with a straightforward behavioral approach and two multimodal approaches offered by papaprofessionals. All groups showed significant gains, with bibliotherapy clients showing the least absolute improvement. Clinical issues in the use of self-help therapies are discussed. (Author)

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Effectiveness of Nonprescription Therapies for Problem Drinkers

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Effectiveness of Nonprescription Therapies for Problem Drinkers

Alcohol abuse is clearly one of the most pervasive and destructive of contemporary human problems. Cahalan (1970) has estimated the prevalence of problem drinking in America to be approximately 9% of the total adult population, or about 16,000,000 people. Being directly tied to more than 86,000 deaths per year, alcohol abuse constitutes the third leading cause of death in the United States.

Yet somehow alcoholism and problem drinking have been largely spared the onslaught of self-help books that have rushed to the aid of the suffering obese, depressed, unassertive, divorced, anxious, shy, and unsexy. Books written directly for the problem drinker have been relatively rare (in spite of countless volumes about alcoholics), and those that are available have consisted mostly of reflections, recollections, and conjectures regarding the proper route to abstinence (e.g., Weston, 1964). More recently self-help materials have begun to appear designed to help problem drinkers moderate their use of alcohol without becoming totally abstinent (Amit, Sutherland & Weiner, 1977; Miller & Muñoz, 1976; Robbins & Fisher, 1973; Winters, 1977). Still more recent have been attempts to evaluate the effectiveness of self-help literature for problem drinkers.

The present paper examines therapeutic applications of self-help materials with problem drinkers. Discussion will include (1) a brief consideration of abstinence vs. controlled drinking as treatment goals, (2) a survey of available nonprescription aids and their applications, (3) a presentation of relevant research regarding nonprescription treatments, and (4) a consideration of clinical issues in the application of such therapeutic adjuncts.

Abstinence vs. Controlled Drinking as Treatment Goals

The option of controlled drinking as a treatment goal for problem drinkers has been a recent and controversial addition to the field of alcohol treatment, where total and lifelong abstinence has been traditionally held to be the only acceptable goal for alcoholics. A thorough consideration of this issue is beyond the scope of this paper, and has been addressed elsewhere (Miller & Caddy, 1977; Pattison, Sobell & Sobell, 1977). Suffice it to say that the following assertions are soundly supported by current research data: (1) Moderate drinking outcomes can and do occur among persons previously diagnosed as alcoholics; (2) A substantial percentage of (though clearly not all) problem drinkers who enter treatment seeking controlled drinking can attain moderation through behavioral/educational methods; (3) Abstinence is the only safe and realistic treatment goal for some problem drinkers, particularly those with more severe or advanced problems. An approach oriented toward moderation may have the additional advantage of encouraging problem drinkers to seek help or to take self-help steps earlier in the development of the problem, before severe physical damage, social maladjustment, and addiction make treatment more difficult and increase the necessity for total abstinence. A truly comprehensive intervention program for problem drinkers should include both abstinence- and control-oriented modalities among its offerings.

Available Nonprescription Aids for Problem Drinkers

A wide variety of educational materials regarding alcoholism and problem drinking are available. Among the major suppliers of these are:

Hazelden Literature Department
Hazelden Books
Box 176
Center City, Minnesota 55012

National Clearinghouse for Alcohol Information
National Institute on Alcohol Abuse and Alcoholism
P. O. Box 2345
Rockville, Maryland 20852

Tape recorded educational materials are also available. Two recent programs of this nature are:

Nathan, P. E. Behavioral assessment and treatment of chronic alcoholism. Biomonitoring Applications, Inc., 270 Madison Avenue, New York, New York 10016. (1976. Two tapes designed for use by professional audiences)

Hamburg, S. R., Miller, W. R., & Rozynko, V. Understanding alcoholism and problem drinking. Social Change Associates, 307 Magnolia Street, Half Moon Bay, California 94016. (1977. Five tapes for general audiences, with accompanying course materials)

A slide rule device for teaching calculation of blood alcohol concentration is available for $1.95 from the Journal of Studies on Alcohol, Rutgers University Center of Alcohol Studies, Rutgers University, New Brunswick, New Jersey 08903. Called the Alco-Calculator, it permits estimation of blood alcohol level from body weight, amount of alcohol consumed, and period of drinking (cf. Compton & Vogler, 1975, for data on accuracy of this instrument).

A range of self-testing devices are available to individuals wishing to monitor their own blood alcohol via breath samples. Sobell and Sobell (1975) found satisfactory accuracy in a simple and inexpensive self-testing unit called the Mobat, manufactured by Luckey Laboratories, Inc., 7252 Osbun Road, San Bernadino, California 92404.

Miller and Muñoz (1976) have provided a self-help manual for persons who desire to moderate their use of alcohol. This book contains a step-by-step behavioral self-control training program as well as several appendices for professionals. Research regarding this manual is discussed below.

Two self-help organizations have arisen to help drinkers wanting to gain greater self-control. Drinkwatchers, founded by Ariel Winters, has chapters throughout the country and provides a self-help manual (Winters, 1977). Responsible Drinkers, Inc. has several chapters located in the San Francisco Bay area. The central addresses for these two organizations are:

Association of Drinkwatchers
P. O. Box 179
Haverstraw, New York 10927

Responsible Drinkers, Inc.
P. O. Box 1062
Burlingame, California 94010

The oldest self-help organization for alcoholics is, of course, Alcoholics Anonymous. A.A. is designed to provide information and support to help alcoholics achieve and maintain total abstinence. Chapters are located in most cities, and the central address is:

Alcoholics Anonymous
P. O. Box 459
Grand Central Station
New York, New York 10017

Finally, the National Council on Alcoholism provides information and referral services through numerous chapters and nonprofit organizations throughout the United States. The central address is:

National Council on Alcoholism, Inc.
733 Third Avenue
New York, New York 10017

Applications of Therapeutic Adjuncts

Christensen, Miller and Muñoz (1978) have recently presented a model for the use of therapeutic adjuncts in expanding mental health service delivery systems. In addition to describing a range of adjunct types they discussed numerous possibilities for the application of adjunctive agents in prevention, treatment, and maintenance of therapeutic gains. Adjuncts may be used as replacement (instead of formal therapy), as concomitant aids (to accompany therapist-directed treatment for a problem), as complement (focusing on one problem area while therapy is directed to other problems), and as supplement (to improve maintenance of gains following termination of therapy). The effectiveness of adjuncts in each of these roles must be evaluated. It should not be assumed that because a therapeutic method "works" in the hands of a therapist it will also be effective in self-help form, or that because an adjunct functions well in one role (e.g., as a concomitant to therapy) it will also perform well in another (e.g., as a replacement for therapy).

We will now turn our attention to research that has evaluated the effectiveness of various types and applications of nonprescription agents in the treatment of problem drinkers.

Research on Nonprescription Therapies

It has long been believed, and not without reason, that all treatment methods for alcoholism are equally effective (or ineffective). In a survey of 384 outcome studies Emrick (1975) found (a) that type of treatment is not a powerful determinant of outcome, (b) that about 42% of cases showed improvement with little or no therapeutic intervention, and (c) that treated alcoholics were not significantly more successful in attaining abstinence than were untreated alcoholics, although treatment did significantly increase the total number of "improved" cases. These findings point to the presence of a developmental or nonspecific process in the recovery of problem drinkers, and suggest the usefulness of minimal treatment groups as a standard against which to judge the effectiveness of more extensive interventions (cf., Christensen et al., 1978; Glasgow & Rosen, 1978; Rosen, 1976).

More recently Vogler and his colleagues (Vogler, Compton & Weissbach, 1975; Vogler, Weissbach & Compton, 1977; Vogler, Weissbach, Compton & Martin, 1977) found no significant differences in effectiveness among treatment modalities ranging from a minimal educational program to an extensive and expensive individual treatment package. It is noteworthy that their overall improvement rate more closely resembles that of Emrick's (1975) treated groups than that for untreated or minimally treated clients. These findings further support the cost-effectiveness as well as absolute effectiveness of minimal interventions for problem drinkers.

My own program of research, aimed at developing a cost-effective treatment program for problem drinkers desiring moderation, began in 1974. The first study (Miller, 1978) evaluated the relative effectiveness of three treatment modalities: (a) electrical aversion therapy, (b) behavioral self-control training, and (c) an extensive individual treatment program similar to that provided by Vogler et al (1975) and modeled after techniques described by Sobell and Sobell (1973) and by Lovibond and Caddy (1970). All three modalities involved individual therapy sessions and proved to be about equally effective. From this it seemed reasonable to conclude that behavioral self-control training, which required the least therapist contact and no special equipment, is the most cost-effective of these approaches.

The finding most relevant to our present concerns, however, emerged somewhat serendipitously. With Ricardo Muñoz I prepared a brief self-help manual that included the basic instructions for behavioral self-control and also included consideration of motivations for drinking, with suggested alternative coping strategies such as progressive deep muscle relaxation and assertion training. We had originally intended to distribute this to all treated clients at termination, but decided instead to randomly select half of our cases to receive the manual. The other half were not given the manual until the three-month follow-up interview. The result was that clients who received and read the manual showed continued gains over follow-up, and were significantly more improved at follow-up than were those who did not receive the manual (who remained at the level attained at termination). One unexpected finding was that clients who received but did not read the manual were the most improved of all at termination (when the manual was first distributed), having already reached the level that was eventually attained by the "readers" at follow-up. One interpretation is that they "didn't need" the manual. At follow-up this group did not differ from those who received and read the manual.

So here was an interesting and unplanned finding - that a self-help manual used as a supplement to therapy significantly improved maintenance of gains. We particularly noted that the manual seemed most beneficial to clients in the aversive counterconditioning group, who had not received self-control training and for whom it thus contained the most new information.

This raised a new question: How effective could such a manual be by itself, without the assistance of a therapist? (Actually our original question was: How much better will clients do with the help of a therapist than with only a manual?) In our second study (Miller, Gribskov & Mortell, Note 1) we randomly assigned 31 clients to a Manual Only group, who were interviewed and then provided with a manual and mail-in self-monitoring cards, or to a Manual Plus Therapist group, who received ten individual therapy sessions focusing on the same self-control methods covered by the manual. The results (reported briefly by Miller, 1977) surprised us. Both groups were quite successful, with no significant differences on outcome variables. The differences that did obtain were in favor of the manual only group, which was maintaining an 84% improved rate at three month follow-up compared to a 79% rate in the therapist-administered group.

Following this study, an expanded version of our self-help manual was published by Prentice-Hall under the title How to Control Your Drinking (Miller & Muñoz, 1976). Also at this point I moved from Oregon to the San Francisco Bay area, and decided to explore the feasibility of providing this kind of self-control training within a group setting. We offered classes in self-control for drinkers through the Sunnyvale Community Center. In the course of a year we offered four such classes, this time using our expanded manual as a textbook (concomitant). Of the 27 problem drinkers completing all or most of this class, 19 (70%) were considered moderately or considerably improved, 6 were considered slightly or not improved, and 2 were lost to follow-up. The results were still encouraging by comparison with Emrick's (1975) normative statistics on treatment outcome, but the success rate was notably lower than that attained by manual only clients in our second study. Data from this third study (Miller, Pechacek & Hamburg, Note 2) have been briefly reported by Miller (1977).

Still another move brought me to my present position at the University of New Mexico, where our two most recent studies were conducted (Miller & Taylor, Note 3, Note 4). The first of these was designed as a partial replication of the preceding three studies. A total of 41 clients were randomly assigned to one of four treatment conditions: (a) Manual Only, (b) Behavioral Self-Control Training with individual therapist, (c) Behavioral Self-Control Training Plus Relaxation Training with therapist, and (d) Group Therapy including relaxation training and replicating the self-control classes of our third study. At three-month follow-up the "success" rates (abstinent + considerably improved + moderately improved, as described by Miller, 1978) were, respectively, 83%, 80%, 75%, and 100%. Preliminary data from one-year follow-up (with 92% of cases interviewed) provided the following success rates, again in the order of groups presented above: 75%, 40%, 75%, and 89%. These findings replicate the cost-effective superiority of the Manual Only condition over all alternatives except group therapy.

Our fifth and most recent study was designed to explore the relative contribution of a broad spectrum component when added to the basic program in behavioral self-control training. Clients were randomly assigned to one of four treatment modalities: (a) Manuals Only, wherein clients received a copy of Miller & Muñoz (1976) and their choice of three additional self-help manuals from a selection of behaviorally-oriented books chosen to deal with motivations for drinking; (b) Behavioral Self-Control Training, involving six weeks with an individual therapist; (c) Behavioral Self-Control Training Plus Designated Modules in relaxation training, communication skills, and assertion training; and (d) Behavioral Self-Control Training Plus Individualized Modules, chosen by the client from 10 alternative modules focusing on motivations for drinking (e.g., insomnia, anxiety, depression). Each module was four weeks in length, was therapist-directed, and was based upon behavioral intervention strategies. Groups (c) and (d) thus received 18 weeks of therapy, as compared to six weeks for (b) and no therapy for (a). Preliminary data from termination(100% of clients interviewed) yielded the following percentages of successful outcome: (a) 60% (b) 70%, (c) 89%, (d) 89%. For the first time in our five years of research the "expected" pattern of findings was obtained, with successful outcome being associated with increasing amounts of therapeutic contact. It should be noted that these are preliminary findings and that follow-up interviews have not yet been conducted. Nevertheless this is the lowest percentage of success that we have observed for a bibliotherapy group.

Clinical Issues

Almost all of the nearly 200 clients treated in these five studies were self-referred to outpatient clinics advertised to help problem drinkers to attain controlled drinking. This population is therefore probably motivated for treatment and subject to a range of nonspecific factors favorable to improvement. The extent to which improvement in bibliotherapy groups is attributable to specific (manual) versus nonspecific factors in unknown, in part because we have not chosen to include "no treatment" controls in our studies. The importance and interpretability of findings from no treatment groups in this kind of research, however, is somewhat questionable. Emrick (1975) has suggested that lower improvement rates in comparison groups may often be due to the detrimental effect of such groups on clients (e.g., disappointment, rejection, negative expectancy). It is also questionable whether clients in such groups truly receive no treatment, considering the availability of treatment alternatives, self-help manuals, sympathetic friends, etc. It may be that minimal treatment is the most appropriate yardstick against which to measure relative effectiveness of more extensive interventions (unless, of course, spontaneous remission rate exceeds that from minimal treatment, which does not appear to be the case for problem drinkers). Existing data on recovery rates among untreated individuals, particularly among those not seeking treatment (e.g., Emrick, 1975) may also provide standards for comparison, although comparability of populations must be considered.

Given our findings and those of Vogler's group regarding the approximately equal effectiveness of minimal and extensive interventions, how should the clinician proceed in prescribing nonprescription vs. formal therapies for problem drinkers? It would be helpful to have data regarding differential predictors of success in self- vs. therapist-administered programs. Lacking

such data (as we currently do) we are left to proceed from base rates of success and from cost-effectiveness considerations, both of which would recommend a self-directed approach as the "first try."

Recommending nonprescription alternatives can be a tricky process, particularly because of the potential detrimental effects of perceived rejection and negative expectancy. In the studies described above we took care to present the bibliotherapy conditions in positive terms and to minimize communications that could be interpreted as rejection. It may be that self-directed therapy is at least as effective if not more effective for many problem drinkers than are externally-directed programs where responsibility for change can be placed on another person. Writers in the areas of attribution (e.g., Kopel & Arkowitz, 1975; Valins & Nisbett, 1971) and of alcoholism (e.g., Caddy, 1972; Jones & Berglas, 1975) have attested to the beneficial effects of internally attributing therapeutic change, a process that may be maximized by self-therapy and may be deterred by the addition of a therapist.

Given reasonable precautions regarding the communication of concern and expectancy, carefully selected nonprescription measures may be the most benign of initial interventions. Certainly follow-up procedures should accompany this practice so that clients not experiencing progress within a reasonable amount of time could be provided with more extensive intervention. This would approach a levels-of-care model that could maximize the efficient use of professional time (Christensen et al., 1978). Screening procedures should also accompany this type of model to ensure that clients in crisis or other special conditions are not routinely assigned to nonprescription services.

These procedures describe the possible use of nonprescription therapies within an existing service delivery system for problem drinkers. Neither these procedures nor the research described above cover the more general case of a self-diagnosed individual pursuing self-therapy through nonprescription means without contacting a therapist. Populations seeking treatment through an agency are probably not representative of those who purchase self-help books on their own. With regard to problem drinkers we have virtually no information about the effectiveness of nonprescription therapies under such conditions. We could speculate that self-help measures might be quite effective because of maximization of internal attribution and because they reach the population in need at an earlier point than do formal therapeutic services. We could equally maintain that potential harm may occur through attempting a nonprescription intervention and failing (Rosen, 1976). The task of designing and conducting research to evaluate nonprescription measures in naturalistic settings will be as challenging as it is important.

We can, at any rate, anticipate an unsurge in the number of self-help books, groups, articles and advertisements offering if not promising successful moderation as the "controlled drinking" approach to prevention and treatment of problem drinking continues to gain in popularity. The beginnings of such a trend are already evident. It is likely that many such self-help measures will neither be evaluated nor be based upon empirically validated methods. The range and limitations of procedures for effecting moderation of alcohol use will be important topics for outcome research in the years ahead.

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